SIGNIFICANCE OF FAMILY THERAPY IN TREATMENT OF ADOLESCENT SUBSTANCE-ABUSERS

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ABSTRACT

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SIGNIFICANCE OF FAMILY THERAPY IN TREATMENT OF ADOLESCENT SUBSTANCE-ABUSERS

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The overall objective of this study is to investigate family factors in adolescent substance-abuse and the significance of family therapy as part of adolescent substance-abuse treatment. The proposal underlying the study was that adolescents who received structurally-oriented individual-family therapy during inpatient substance-abuse treatment would demonstrate a higher level of functioning on several variables than adolescents who did not receive this type of therapy.

A static group comparison design was used in the study. The adolescents' level of functioning was defined in terms of the following variables: (a) self-esteem, (b) depression and (c) attitudes towards family. A questionnaire was administered to adolescents in clinical and community settings. The results of the study indicated a direct and positive association between structurally-oriented individual-family therapy and a higher level of functioning.

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CHAPTER ONE

INTRODUCTION

The past decade has seen widespread concern over the problem of substance-abuse and its implications for adolescents. The causes and ramifications of substance-abuse in today's society are multifaceted, complex, and confusing. D. J. Lettieri (1983) states that "drug abuse is a complex contemporary social problem. Its complexity derives in part from the impact it has on the individual user psychologically, socially, and biologically, and in part from its effect on society, law, economics, and politics" (p. 9). Although a diversity of theories on substance-abuse exists, each theory stressing a particular set of factors, there is growing recognition that the problem of adolescent substance-abuse cannot be addressed by focusing strictly on one set of variables. A comprehensive intervention deals with the individual in his or her environment. In the case of adolescents, the primary environmental and socializing influence is the family. For this reason, an approach is necessary which deals with the family, not only with the adolescent substance-abuser. Although the adolescent may be the "identified patient," the

family itself must receive treatment in order to break the cycle of substance-abuse.

The purpose of this study is to describe family factors which contribute to substance-abuse in adolescents, and to point out the need for family therapy as part of inpatient treatment for adolescent substance-abusers.

Statement of the Problem

Numerous family factors are believed to be related to substance-abuse in adolescents (Frankel, 1985). For example, adolescents who feel close to their families are less likely to begin abusing alcohol and drugs than adolescents who feel distant from their families, whose parents disagree about family rules and parental discipline, or who feel "controlled," rather than understood, by their parents (Friedman, 1985). Also, adolescents whose parents use alcohol and drugs are much more likely to begin using these substances themselves (Kandel, 1974).

Findings of the National Youth Polydrug Study (Friedman et al., 1980) have indicated that teenagers whose parents have alcohol or drug problems, legal problems, or psychiatric problems such as depression, tend to abuse substances more frequently, and more

severely, than teenagers whose parents did not have such problems. The Study also indicated that the "youngest children," that is, children whose siblings are all older, tend to abuse substances more frequently and severely than "older children," that is, children who have younger siblings. In addition, research findings by Friedman (1985) have pointed out that a significant positive correlation exists between the number of overall family problems and the number of different substances abused by the adolescent.

Families of adolescent substance-abusers have been noted to possess patterns of communication and interaction which may be described as characteristic of these families (Frankel, 1985). For example, the parents may keep the adolescent in an overly-dependent role and undermine his or her self-esteem. At the same time, the parents may berate the adolescent for refusing to grow up. In many cases, the adolescent is the symptom carrier for the family illness. The adolescent's substance-abuse problem may be an important part of maintaining the family homeostasis, or balance (Stanton & Todd, 1982). The adolescent's problem may provide the parents an opportunity to fight over the adolescent, rather than fight openly with each other (Friedman, 1985). The adolescent and the parents may

form alliances which separate the parents from each other (Stanton, 1979). The adolescent's substance-abuse problem reinforces the parents' need to control the adolescent, yet the control is inadequate and the cycle of substance-abuse continues (Kaufman, 1985).

Friedman (1985) in his article, "Family factors and the family role in treatment for adolescent drug-abuse," gives the following description of the adolescent substance-abuser's family system:

> In certain families, the degree of dysfunction, conflict and discord, and lack of healthy, sustaining, stabilizing family milieu, or the degree and type of family emotional deprivation, lack,, loss, and pain, are conducive to serious, self-destructive drug-abuse by an adolescent member. In a vicious cycle, the drug-abuse behavior then leads to an intensification of the discord and conflict in the family. This unresolved conflict then often feeds into more acting out and increased use of drugs by the adolescent. (p. 14)

The following statistics indicate the magnitude and severity of the adolescent substance-abuse problem in

the United States, and the need for developing effective interventions to deal with this population.

In the metropolitan Atlanta area in 1980, of the 1,415 substance-abuse cases admitted to federally-funded substance-abuse programs, 10% were adolescents under age 18. 17% of all adolescents admitted to federally-funded substance-abuse treatment programs in the Atlanta area in 1980 reported first using substances at ages 18-19. 14% reported that they had first used substances at ages 16-17, 95 at ages 14-15, and 7.5% reported that they had first used substances at age 14 or younger (National Institute on Drug Abuse, 1981).

The percentage of adolescents comprising the total number of substance-abuse admissions rose in 1981 from 10% to 11.7%. Of all adolescents admitted to federally-funded substance-abuse treatment programs in 1981, 65% listed marijuana as the primary substance of abuse, 10% listed amphetamines, 4% listed alcohol, 5% listed cocaine, 3% listed PCP, and 2% listed barbiturates and heroin. Abuse of PCP and heroin was highest among Black and Hispanic teenagers, while abuse of amphetamines and cocaine were highest among white adolescents. Marijuana and alcohol were abused by all groups (National Institute on Drug Abuse, 1982). Findings from the 1981 survey conducted by the National Institute on Drug Abuse

indicated that of the total number of 249,762 substance-abusers admitted to federally-funded treatment programs, 28,871, or approximately 11%, were under the age of 18. The 1982 survey conducted by the National Institute on Drug Abuse indicated that 26.7% of the adolescents surveyed reported having used marijuana, 13.2% reported having used cocaine or other stimulants, 5.2% reported having used hallucinogens, 11% reported having used sedative or tranquilizers, and 65% reported having used alcohol.

A nationwide survey of high school seniors (e.g., Johnston, O'Malley & Bachman, 1983) indicated that out of 16,000 high school seniors surveyed, 16.2% had used cocaine, while a ;much larger percentage had used alcohol and marijuana. In the South, the same survey indicated that over 50.8% of the students surveyed had used drugs. In fact, 22.9% of the students reported having used drugs within the last 30 days.

According to a 1987 national survey of high school seniors, 92% of all high school seniors have used alcohol, 4.3% have used cocaine, and 50% have used marijuana. Over 90% of adolescents try alcohol before reaching the legal drinking age, and 30% of adolescents nationwide are estimated to have a drinking problem (National Institute on Drug Abuse, 1987).

In the light of the statistics above, which indicate the magnitude and severity of the adolescent substance-abuse problem in the United States, social workers must find effective interventions to use with this population. The purpose of this study is to determine the effectiveness of a structurally-oriented family approach to treatment with adolescent substance-abusers.

Significance of the Study

Family therapy has long been used effectively in the treatment of alcohol-abuse programs with adults (Stanton, 1979). In the past two decades, the use of family therapy has spread to the drug-abuse treatment field (Coleman & Davis, 1978).

In 1974, D. Huberty made a presentation to the North American Congress on Alcohol and Drug Problems. The focal point of his presentation was that adolescent substance-abuse was a family affair:

> ...The role of the family in supporting use of drugs by one of its members, is a critical issue which is currently being addressed by a growing number of people...Despite the burgeoning development of therapeutic communities, drug treatment units in community

> mental health centers and psychiatric hospitals...most treatment has been only temporarily successful. The most common forms of treatment have failed...treating drug abusers apart from their families is an exercise in futility. (p. 12)

In 1978, a national survey of drug treatment programs (Coleman & Davis, 1978) indicated that of the 2,012 programs surveyed, 93% provided some form of family therapy as part of their drug-abuse programs. 74.2% of drug-abuse programs rated family therapy as being highly important for the drug-abuser's process of recovery. Furthermore, 75% of treatment programs employed individual-family therapy, in which the drug-abuser and family are seen together, as opposed to separate therapy sessions for the drug-abuser and family members.

In the 1980's the concept of co-dependency has received much attention in substance-abuse treatment settings and in the professional literature (Black, 1982; Cermak, 1988; Wegscheider, 1985; Woititz, 1985). Co-dependent families are adversely affected by the substance-abuser's illness while contributing to the problem. Therapists and substance-abuse counselors are encouraging their substance-abuse clients to explore

family rules and roles. In spite of this increased awareness of the role of the family in substance-abuse problems, few definitive studies have been performed. Qualitative research studies (Huberty, 1974; Wellisch & Hays, 1973) have yielded insufficient outcome data to provide evidence of a direct and positive relationship between family therapy and beneficial results for the substance-abuser (Stanton, 1979).

The need for a study of family therapy as a necessary part of adolescent substance-abuse treatment arises from the urgency to find a solution to the problem of adolescent substance-abuse. My own interest in family factors pertaining to adolescent substance-abuse began several years ago. This interest increased during a three-months period that I worked as a volunteer intern at an adolescent treatment facility. Some of the adolescent substance-abusers in treatment received individual-family therapy, while others had therapy sessions separately from their families, and others received no family therapy at all. As I read the professional literature on adolescent substance-abuse, I began to believe that adolescents who received individual-family therapy during treatment would have a better chance of recovery than adolescents who did not.

Considering the rising rate of adolescent substance-abuse, I believe it is essential that social workers reach a better understanding of the factors contributing to this problem. The professional literature indicates the importance of the family in both substance-abuse and recovery from substance-abuse in adolescents. The literature also indicates a lack of outcome data concerning the effectiveness of family therapy with adolescent substance-abusers. A direct study of an adolescent substance-abuse population in clinical and community settings, would partially fill this knowledge gap and facilitate more effective interventions for adolescent substance-abusers.

Many adolescents are evaluated by emergency or crisis services because of substance-abuse problems. In a crisis situation, it is essential for the social worker to make an accurate assessment not only of the immediate problem, but of the environment in which the problem exists. The social worker must evaluate the adolescent's family situation, because the family is the "environment" in which the adolescent lives. The family system provides the rules, roles, and behaviors which the adolescent must accept or reject.

Adolescence is a problematic time of life for both the adolescent and the family. The adolescent's

substance-abuse can serve the purpose of prolonging his or her growing up and leaving the family. On the other hand, substance-abuse can give both the adolescent and his or her parents a reason to mutually reject each other (Friedman, 1985). Adolescence is the time during which the child begins to grow up, to separate from the family, ,to function independently and to assert himself or herself. However, an adolescent with substance-abuse problems does not separate from the family in a normal manner. The adolescent substance-abuser's separation is filled with dependency issues anger, and hostility. He or she not only leaves the family system, but leaves its morals and values as well (Frankel, 1985).

In the families of adolescent substance-abusers, the parents often resist the adolescent's growing up and functioning independently. When this happens, a chronic, repetitive process takes place. The family essentially becomes "stuck" at this stage. The adolescent retaliates through substance-abuse, which provides a paradoxical solution: the adolescent gives the appearance of independence, while actually he or she is overly dependent on the family, either physically, emotionally, or both. It is a process of <u>pseudo-individuation</u>, rather than healthy individuation (Stanton, 1979).

These are a few aspects of family dynamics of adolescent substance-abusers which social workers might take into consideration when evaluating an adolescent who has a substance-abuse problem.

Feelings and attitudes towards family members also play an important part in the adolescent's recovery. The professional literature contains a scarcity of research studies conducted with adolescents following discharge from treatment (Stanton, 1979). However, just as adolescents who feel close to their families are less likely to begin substance-abuse (Friedman, 1985), it stands to reason that adolescents who develop a more accepting and less conflictual relationship with their families, are more likely to successfully recover from substance-abuse (Friedman, et al., 1980).

A significant aspect of this study is that it measures the feelings and attitudes of adolescents both in treatment settings and community settings. The adolescents in the community have been discharged from inpatient adolescent substance-abuse programs, and are in various stages of recovery from substance-abuse. The premise is that adolescent substance-abusers who have a good relationship with their families will function better in the community than peers who have poor relationships with their families.

Since very little research has been conducted with adolescent substance-abusers who are no longer receiving treatment, this study should provide some knowledge of the importance of adolescents' feelings towards family as a factor in recovery from substance-abuse.

CHAPTER TWO

REVIEW OF LITERATURE

Although the effectiveness of family therapy as a treatment approach to adolescent substance-abuse has not yet been definitively proven, the professional literature has indicated that family therapy is generally beneficial. The premise is that improvement in family communication and interaction patterns disrupts the cycle of substance-abuse. This disruption combined with the enactment of more productive interaction patterns, allows the adolescent to individuate from the family in a normal, healthy manner (Frankel, 1985; Friedman, 1985; Stanton & Todd, 1982).

The type of family therapy most widely used with adolescent substance-abusers is individual-family therapy. In this type of therapy,. the members of an individual family attend sessions together with a therapist or co-therapists. Other types of family therapy which are used with adolescent substance-abusers are: (a) group marital therapy for parents of substance-abusers, (b) concurrent but separate therapy sessions for substance-abusers and families, (c) group therapy for siblings of substance-abusers, (d) multiple-family therapy, and (e) social network therapy.

In a review of the professional literature on family approaches to adolescent substance-abuse treatment, Stanton (1979) has cited several studies which have employed individual-family therapy for substance-abusers, with favorable results. Wellisch and Hays (1973) conducted a study of individual-family therapy with five adolescent substance-abusers and their families in an inpatient setting. The researchers reported that the results of the therapy were generally beneficial, although no definite outcome data were obtained. Haagland and Pyllkanen (1974) managed to obtain follow-up information on 25 adolescent substance-abusers following discharge from an inpatient unit. While in treatment these adolescents had received individual-family therapy in combination with individual and group therapy. Haagland and Pyllkanen reported that the outcome data demonstrated overall favorable results, but the findings were tentative due to lack of control or comparison groups. Kempler and MacKenna (1975) conducted individual-family therapy with 12 adolescent substance-abusers and their families. In this case, the researchers were able to demonstrate clearly favorable results in six of the families. However, the remaining six families showed unfavorable results. Huberty (1974) conducted studies of individual-family

therapy with adolescent substance-abusers. In this case the researcher demonstrated some degree of success, but offered no clear outcome data.

Stanton (1979) has also cited studies conducted by Boszormenyi-Nagy and Spark (1973), Jonckheere (1973), Noone and Reddig (1976), and Reilly (1976). These studies, like those described above, yielded tentative but promising results but no definitive outcome data. The point which these studies illustrate is that while numerous studies have been conducted, very little quantitative data has been generated to demonstrate the effectiveness of individual family therapy with adolescent substance-abusers.

Two studies have been conducted using comparison groups and yielding quantitative data. However, both these studies were performed with adult substance-abusers, not adolescents. Stanton and Todd (1976) assigned subjects to three comparison groups using individual-family therapy and two other types of family therapy. The researchers reported favorable outcomes for all three groups receiving family therapy. A fourth group, the control, received no family therapy. Ziegler and Driscoll (1977) performed another of the few studies using comparison groups and yielding outcome data. 79 adult substance-abusers and families were randomly

assigned to three groups: (a) an individual-family therapy group, (b) a concurrent parent group, and (c) a control group. Although the initial outcome data showed no difference among the three groups, subsequent investigation of the data demonstrated that certain subsets of the comparison groups indicated beneficial change as a result of family therapy, compared to subsets of the control group.

Stanton and Todd (1982) have stated that treatment with adolescents differs from that of adult substance-abusers. Treatment of the adolescent relates to a different stage of development, including not only the adolescent but the entire family system. The following differences occur between therapy with adolescent substance-abusers and adult substance-abusers: (a) adolescents tend to be less severely and chronically involved with substance-abuse than adults, meaning that therapy may be of a simpler, more short-term nature; (b) adolescent families are less resistant to entering therapy than adult families, and the therapist is perceived as having more authority when the patient is an adolescent rather than an adult; and (c) adolescents are actually less dependent on peer group influence than adults, and more dependent on family influence.

Kaufman (1985) has indicated the need for a structurally-oriented approach to individual-family therapy with adolescent substance-abusers. Structural family therapy as developed by Minuchin (1974) has gained wide acceptance in the adolescent substance-abuse treatment field as an effective method of family therapy. The thrust of the structural approach is to restructure the family system. The goal of structural family therapy is to improve family organization by rearranging the family's present patterns of communication and interaction. Some of the primary concepts of structural family therapy are: (a) structural therapy uses techniques such as unbalancing a system and intensifying an interaction as part of therapy (Stanton & Todd, 1982); (b) careful attention is given to proximity and distance between family members; (c) attention is also paid to family subsystems, such as the parental dyad and the sibling subsystem; (d) rules which determine how family interaction is achieved by various members are critical, and these rules are defined in boundaries (Minuchin, 1974); and (e) a family is described in terms of its hierarchies, alliances or coalitions, and problems in family functioning are seen to result from a rigid,

dysfunctional family structure (Minuchin, 1974; Stanton & Todd, 1982).

A critical element in structural therapy is the joining process. According to this process, the therapist "joins" the family, becoming an active participant in family interactions while remaining objective enough to restructure these interactions as they occur (Stanton & Todd, 1982). The three primary joining techniques are: (a) maintenance, in which the therapist maintains the family system by being supporting to the family members, while the therapist prepares to restructure family interaction patterns; (b) tracking, in which the therapist encourages family members to communicate in their usual manner, allowing the therapist to observe communication and interaction patterns; and (c) mimesis, in which the therapist adapts to the family's mood and interaction style, allowing the therapist to be assimilated into the family during therapy sessions (Minuchin, 1974).

In order to improve the family's functioning, the structurally-oriented family therapist first joins the family, then restructures it by establishing boundaries around the various family subsystems. These boundaries encourage the differentiation between the parental subsystem and the adolescent subsystem. This has the

effect of strengthening the parental dyad, while simultaneously reinforcing the boundary around the adolescent and peer group. Such a structural shift helps the adolescent to begin the necessary process of individuating himself or herself from the family, eventually leaving the family to pursue his or her own goals (Stanton & Todd, 1982).

Structural techniques that have produced favorable results with adolescent substance-abusers and families include: (a) establishing and strengthening boundaries around family subsystems, (b) enacting dysfunctional family interaction patterns during therapy in order to introduce more functional structures and patterns, (c) unbalancing the homeostasis of the family system by siding with various family members or subsystems, and (d) demonstrating to the family that each member has areas of competence, resources, and untapped strengths which the family does not perceive (Stanton, 1979). The structural approach is an excellent choice for therapy with adolescent substance-abusers and families because of its goal-oriented and short-term nature. It is relatively cost-effective and produces therapeutic change in families within a limited number of sessions. The short-term factor is significant, since adolescent

substance-abusers and families appear to have a limited capacity for handling pain and stress (Stanton, 1979).

The effectiveness of structural individual-family therapy with adolescent substance-abusers has not yet been definitively proven. However, the professional literature has indicated that structurally-oriented individual-family therapy is beneficial to adolescent substance-abusers and their families (Frankel, 1985; Kaufman, 1985; Stanton, 1979; Stanton & Todd, 1982).

Overview of the Major Theoretical Orientations

Lettieri (1983) defines five phases which comprise the cycle of drug-abuse: (a) initiation of drug use, (b) continuation of drug-use, (c) transition from drug use to drug abuse, (d) cessation of drug abuse, and (e) relapse into drug abuse. In a summary of selected theories on drug-abuse, Lettieri classifies theories on drug-abuse into four categories: (a) theories which explain drug-abuse in terms of the drug-abuser's relation to himself or herself, (b) theories which explain drug-abuse in terms of the drug-abuser's relationship to others, (c) theories which explain drug-abuse in terms of the drug-abuser's relationship to society, and (d) theories which explain drug-abuse in terms of the drug-abuser's relationship to nature.

Theories from the disciplines of psychiatry and psychology focus on the relationship to self. Social-psychological theories focus on the relationship to others; sociological theories focus on the relationship to society. Biomedical, biological, genetic, and neuro-scientific theories focus on the relationship to nature. The majority of theories on drug-abuse stem from the disciplines of psychiatry, psychology and social psychology, which includes social work.

Psychoanalytic theories. Psychoanalytic theories of drug-abuse focus on the intrapsychic factors of the individual. Drug-abuse may be regarded as the individual's only available means of coping with feelings of disillusionment, loneliness, guilt, anxiety, rage, alienation, and isolation. Physical, psychological, or sexual-abuse in childhood may be linked to drug-abuse in adolescence or adulthood (Lettieri, 1983).

Psychological and personality theories. Psychological and personality theories are based on the cognitive and affective processes of the individual. However, these theories extend to the relevance of family influence on the adolescent's self-concept and ability to cope with responsibility (Lettieri, 1983). Specifically, psychological theories of drug-abuse often

note the existence of a dysfunctional family system (Friedman, 1985; Kaufman, 1985; Lettieri, 1983; Stanton & Todd, 1982). This type of environment tends to create certain personality deficiencies in the adolescent. A lack of emotional and psychological coping skills, in combination with environmental factors, may lead the adolescent to abuse alcohol and drugs (Wodarski & Hoffman, 1984).

Social Psychological and Sociological Theories. Social psychological and sociological theories emphasize peer and family influence, and the interaction of psychological, sociological and environmental factors. Stanton's theory of substance-abuse (Stanton, 1979; Stanton & Todd, 1982) is based on the concept of mutual over-dependence between the substance-abuser and family. Since the primary issue is the substance-abuser's inability to achieve a successful separation from the family, the potential for beginning the substance-abuse cycle is particularly great during adolescence. Kandel (1974) represents substance-abuse as being composed of age and peer-related stages, each of which precedes, but does not necessarily determine the occurrence of, the next stage: (a) cigarettes and alcohol (legal drugs), (b) marijuana, (c) stimulants, depressants and psychedelics, and (d) heroin addiction.

Biomedical theories. Biomedical theories emphasize the biological, genetic, and neurological aspects of the individual. These theories maintain that substance-abuse is a learned behavior resembling an instinct or drive, a genetically inherited trait such as a metabolic deficiency, or an inherent hypersensitivity to anxiety and stress (Lettieri, 1983).

Co-dependency theories. In the past decade, the concept of co-dependency has exerted a great influence on substance-abuse treatment of both adults and adolescents. Co-dependency, which may be loosely defined as mutual and pathological over-dependence, creates "role playing" among family members, while suppressing individualization and the pursuit of developmental goals (Black, 1982; Wegscheider, 1985; Woititz, 1985. According to the co-dependency theory, the substance-abuser is simultaneously the product and the producer of the family dysfunction. Substance-abuse creates an enmeshed and boundariless co-dependent system that does not allow for individual growth or separation, since each member of the family system essentially loses his or her identity while trying to be responsible for the behavior and feelings of the other members of the system (Bonner et al., 1986).

Several studies have concluded that inadequate emotional support by parents and dysfunctional family relationships are related to adolescents' initiation into substance-abuse (Jessor, 1975; Kandel, 1974; Tec, 1971). The adolescent's initiation into the use of illegal drugs is strongly related to parental influences, and parental attitudes closely interrelate with the self-concept and psychological makeup of the adolescent (Kandel, 1974).

Mulford and Miller as cited by Wodarski and Hoffman (1984), performed a significant study on the use and abuse of alcohol by adults and adolescents. Expanding upon the Mulford-Miller study, Wodarski and Hoffman reported that adolescents begin to use alcohol because they perceive this to be an adult behavior. However, adolescents who make the transition from alcohol use to alcohol abuse do so because of feelings of alienation, normlessness, and powerlessness.

Stanton (1979) has stated that while early use of substances by teenagers is primarily peer-influenced, the transition from substance-use to substance-abuse is influenced primarily by the quality of the relationship between adolescent and parents. The evidence, as mentioned above, that adolescent substance-abuse is primarily neither an individual psychological disorder,

nor a peer phenomenon, but a family dysfunction, has created wide interest among professionals in the fields of both substance-abuse treatment and family therapy (Coleman & Davis, 1978; Kaufman, 1985; Stanton & Todd, 1982).

Lettieri (1983) describes the categorization of different theoretical schools of family therapy into three general perspectives: (a) an historic perspective, (b) an interactional perspective, and (c) an experiential perspective.

(1) Historic perspective: understanding. The therapist interprets the past and illuminates the present to help the family understand and recognize the pattern and development of its present problems.

(2) Interactional perspective: transformation. The therapist uses a strategic approach to correct and restructure dysfunctional interactions within the family.

(3) Experiential perspective: identification. The therapist involves the parents and older family members in an approach to create new identification and weaken dysfunctional family dynamics and destructive loyalties among family members.

The structural individual-family approach

incorporates elements from all three of the above perspectives.

Definition of Terms

The Diagnostic and Statistical Manual of Mental Disorders (Third Edition--Revised, 1987) has listed two criteria which differentiate non-pathological, or recreational, substance use from substance-abuse:

A. A maladaptive pattern of psychoactive substance use indicated by at least one of the following:

   (1) continued use despite knowledge of having a persistent or recurrent social, occupational, psychological, or physical problem that is caused or exacerbated by use of the psychoactive substance

   (2) recurrent use in situations in which use is physically hazardous (e.g., driving while intoxicated)

B. Some symptoms of the disturbance have persisted for at least one month, or have occurred repeatedly over a longer period of time. (p. 169)

The DMS-III-R lists nine classes of psychoactive substances associated with abuse and dependence: (a)

alcohol, (b) amphetamine or similarly acting sympathomimetics, (c) cannabis, (d) cocaine, (e) hallucinogens, (f) inhalants, (g) opiods, (h) phencyclidine (PCP) or similarly acting arylcyclohexlamines, and (i) sedatives, hypnotics, or anxiolytics.

The DMS-III-R has differentiated between substance-abuse and substance-dependence, as follows:

> Psychoactive Substance Abuse is a residual category for noting maladaptive patterns of psychoactive substance use that have never met the criteria for dependence for that particular class of substance...This diagnosis is most likely to be applicable to people who have only recently started taking psychoactive substances and to involve substances, such as cannabis, cocaine, and hallucinogens, that are less likely to be associated with marked physiologic signs of withdrawal and the need to take the substance to relieve or avoid withdrawal symptoms. (p. 169)

The DSM-III-R has also indicated that substance-abuse frequently involves abuse of several substances, either at the same time or one substance after another.

The term individual-family therapy is defined as therapy or counseling of members of an individual family, in which a therapist or counselor "helps a family to solve their problems and to achieve more positive and constructive ways of relating to one another" (Coleman, 1976, p.168). An essential aspect of individual-family therapy is that the whole family system is being addressed, rather than a group of separate individuals: "the whole counts more than the sum of its parts, and includes the members plus their interactions" (Olson, 1970, p.506).

The term structurally-oriented therapy is defined as therapy which utilizes structural techniques, including: (a) unbalancing the family system, (b) intensifying family interaction, (c) utilizing proximity and distance between family members, (d) working with family subsystems, (e) utilizing boundaries, hierarchies, alliances and coalitions within the family system, and (f) joining the family system by means of maintenance, tracking, and mimesis techniques.

The term recovery from substance-abuse is defined in this study as abstinence from all psychoactive substances listed by the DSM-III-R, accompanied by a program of personal and spiritual growth. The requirements for a program of personal and spiritual

growth may be considered to be met if the adolescent is regularly attending meetings of Alcoholics Anonymous, Cocaine Anonymous, or Narcotics Anonymous. The term sobriety is also defined for the purposes of this study as abstinence from psychoactive substances accompanied by regular attendance of Alcoholics Anonymous, Cocaine Anonymous, or Narcotics Anonymous meetings.

Self-esteem is defined by the Index of Self-Esteem published in The Clinical Measurement Package, by Walter W. Hudson (1982). Depression is defined by the Generalized Contentment Scale from The Clinical Measurement Package, and attitudes towards family members are defined by the Index of Family Relations in The Clinical Measurement Package.

An adolescent substance-abuser is defined as a male or female between the ages of 13 and 19 who meets the criteria for substance-abuse as listed in the DSM-III-R.

Statement of the Hypothesis

The hypothesis is stated as follows:

Adolescents who receive structurally-oriented individual-family therapy as part of inpatient substance-abuse treatment have (a) higher self-esteem, (b) less depression, and (c)

better family relations, than adolescents who do not receive this therapy.

In this study, adolescents who have received structurally-oriented individual-family therapy as part of treatment have been compared to adolescents who were admitted to inpatient substance-abuse programs, but did not receive this type of family therapy as part of treatment. The two groups of adolescent substance-abusers were compared on the following variables: (a) self-esteem, (b) depression, and (c) family relations.

CHAPTER THREE

METHODOLOGY

Research Design

The research design which has been utilized in this study is the static group comparison design.

The static group comparison design involves an experimental group and one or more comparison groups. The experimental group is exposed to the independent variable (X). The comparison group is not exposed to the independent variable. The comparison group is then compared to the experimental group in order to provide evidence of "an empirical association between the independent and dependent variables" (Grinnell, 1985, p.250).

Grinnell (1985) states that evidence of an empirical association exists if "there is a statistically significant difference between the mean differences of the distributions of one variable with respect to another" (p. 239).

The static group comparison design can be diagrammed as follows:

Experimental group	X	O_1
Comparison group		O_1

In the above diagram, X represents the introduction of the independent variable: structurally-oriented individual-family therapy.

O_1 represents the measurement of the dependent variables: (a) self-esteem, (b) depression, and (c) family relations.

The static group comparison design has been utilized in this study in order to compare two groups of adolescent substance-abusers for statistically significant differences relating to the dependent variables listed above. The experimental group consisted of adolescent substance-abusers who had been exposed to the independent variable, structurally-oriented individual-family therapy. The comparison group consisted of adolescent substance-abusers who had not been exposed to the independent variable, or had been exposed to the independent variable in conjunction with another form of family therapy.

The experimental and comparison groups were tested, then compared in order to determine if statistically

significant differences of the dependent variables existed among the three groups.

Eligibility Criteria

76 adolescent substance-abusers were selected for the study on the basis of the following criteria for eligibility: (a) each adolescent was required to be between the ages of 13 and 19 years of age; (b) each adolescent was required to have a minimum of one admission to an inpatient substance-abuse treatment facility; (c) each adolescent was required to be in recovery from substance-abuse, meaning that while the study was taking place he or she abstained from substances and attended regular meetings of Alcoholics Anonymous, Cocaine Anonymous, or Narcotics Anonymous; (d) adolescents participating in the study could be either male or female; and (e) each adolescent was required to be either living with family members, or seeing his or her family on a regular basis.

Since this is a study of family factors and the significance of family therapy in adolescent substance-abuse treatment, it was necessary for the adolescents to be actively involved with their families at the time the study was taking place.

The adolescents who participated in the study consisted of 46 adolescents residing in the community, and 30 adolescents residing in an adolescent substance-abuse treatment facility. Although the ages of the adolescents ranged from 13 to 19, the largest number of adolescents were in the 16-17 age range. Approximately equal numbers of girls and boys participated in the study.

The Sampling Method

Two criteria existed for selecting the sample for study: (a) selecting a sample which would be representative of the population being studied, and (b) selecting a sample which would be sufficiently large in numbers, and which would be available to the researcher for study.

Three DeKalb County mental health centers with adolescent substance-abuse populations were investigated for the study. Two DeKalb County substance-abuse programs and two state-funded community adolescent treatment programs were also investigated as being possible sites for the study. However, these programs either could not provide a large enough sample, or were already overburdened with studies still in progress.

It appeared that the state and county adolescent programs capable of providing adequate samples were perhaps being "overstudied," therefore the client population would not have provided a representative sample. A private residential facility for adolescents was subsequently investigated. Its adolescent substance-abuse population was found to be eligible and appropriate for the study.

The remaining subjects were drawn from an adolescent substance-abuse population attending Alcoholics Anonymous meetings at the Triangle Club in northwest Atlanta. The Triangle Club is known for its eclectic approach to addiction, and is widely attended by cocaine-users and narcotics-users.

The 76 adolescent subjects comprise a purposive sample, a type of non-probability sampling "predicated on the assumption that the social worker has sufficient knowledge related to the research problem to allow selection of 'typical' persons for inclusion in the sample" (Grinnell, 1985, p. 145).

The adolescents in the sample were, for the most part, white, urban, and middle-class. Although this sample is not representative of all adolescent substance-abusers in the metro Atlanta area, it does represent the adolescent substance-abuse population of

northwest Atlanta. As previously mentioned, this sample was selected because it represented the local, urban, middle-class adolescent population, and because this particular population was accessible to the researcher for study, whereas other populations were either insufficient or inaccessible.

The Population

The population from which the sample was drawn consists of urban adolescents, ages thirteen to nineteen, mostly white, mostly middle-class. The majority of the parents of these adolescents have high-school or college degrees. Some of these adolescents are black, but also middle-class with educated parents. There are few Asian-Americans or Hispanic-Americans in this population, and only one of each was represented in the sample.

The client population of the adolescent residential treatment facility included adolescents from middle and lower-class rural backgrounds. The education level of the parents of these adolescents tended to be tenth-grade level rather than high-school or college degree level. The adolescents themselves appeared to be functioning at a lower educational level per age group than their peers in the community setting.

The majority of adolescent substance-abusers in the community setting (the Triangle Club) had been discharged from inpatient treatment within the past month to two years, and were currently involved in outpatient or aftercare programs.

Both populations were in recovery, which means the adolescents were involved in a program of substance abstinence from substances and personal development. Since the study deals with recovering adolescent substance-abusers, no adolescents were studied who were currently abusing drugs or alcohol, or who were not regularly attending AA, CA or NA meetings. The sample included chronic relapsers, as well as adolescents who were making their first attempt at sobriety.

The Experimental Group. The experimental group consisted of eligible adolescents who had received structurally-oriented individual-family therapy as part of inpatient substance-abuse treatment.

The Comparison Group. The comparison group consisted of eligible adolescents who had not received structurally-oriented individual-family therapy as part of inpatient substance-abuse treatment.

Experimental and comparison groups were not specifically matched in terms of variables such as age, number of times in treatment, or length of abstinence

from drugs and alcohol. All 76 eligible subjects completed the questionnaire, and those who responded that they had never received family therapy, or had received more than one type of family therapy, were assigned to the comparison group. Those who responded that they had received structural individual-family therapy, and no other type of family therapy, were assigned to the experimental group.

Data Collection Procedure

Two different types of measures were employed to collect data for this study. A questionnaire was designed consisting of 42 items. 30 of these items were taken from three measuring instruments included in The Clinical Measurement Package, by Walter W. Hudson (1982).

The Clinical Measurement Package consists of nine scales and indexes "designed to measure the degree, severity, or magnitude of a distinct and separate problem in personal and social functioning" (Hudson, 1982, p. 1). Each scale or index contains 25 items, which is long enough to achieve good reliability, but short enough to be used repeatedly with the same client or client group on a regular basis (Hudson, 1982). The CMP scales can be used in a diversity of situations

and settings, and are appropriate measurement instruments for planned group experiments, surveys, and comparative studies. They are especially useful for evaluating client change. Each scale has a reliability of .90 or better. Each scale has good content, concurrent, factorial discriminant, and construct validity (Hudson, 1982).

Thirty items on the questionnaire were derived from ten items each from three different measuring instruments included in the Clinical Measurement Package: (a) The Index of Self-Esteem, (b) The Generalized Contentment Scale, and (c) The Index of Family Relations. If all three instruments had been included in their complete form, the questionnaire would have consisted of 87 items. This would have been too lengthy and complicated an instrument, since for purposes of the study an instrument was required which was valid, reliable, and which an adolescent could complete in five to ten minutes.

Each of the Hudson instruments was reviewed carefully, and 10 items were selected from the 25 items for each scale or index. The 10 items selected were those which most accurately represented the variable being measured by each instrument: (a) self-esteem (Index of Self-Esteem), (b) depression (Generalized

Contentment Scale), and (c) attitude toward family (Index of Family Relations). These 30 items were included in the questionnaire as a "Feelings Inventory," for the purpose of measuring each adolescent's level of self-esteem, depression, and attitudes toward family.

The Index of Self-Esteem, the Generalized Contentment Scale, and the Index of Family Relations, are described in the following paragraphs, along with the variables measured by each instrument.

(1) Index of Self-Esteem (ISE). The first of the dependent variables, level of self-esteem, will be measured using this index, which is "designed to measure the degree, severity, or magnitude of a problem the client has with self-esteem" (Hudson, 1982, p. 4). The family members' levels of self-esteem are relevant to the research hypothesis, in that low self-esteem in both the adolescent drug-abuser and the family is part of the overall family dysfunction perpetuating the drug-abuse problem (Bry, 1963; Friedman, 1985; Stanton, 1979).

(2) Generalized Contentment Scale (GCS). The second dependent variable, level of depression, will be measured using this scale, which measures "the degree, severity, or magnitude of nonpsycotic depression"

(Hudson, 1982, p. 3). Hudson points out that the ISE and GCS usually correlate highly with each other, as self-esteem is related to depression. The family members' levels of depression are relevant to the hypothesis as indicators of co-dependency, inadequate emotional support, and dysfunctional family relationships (Bonner, Linton et al., 1986; Kandel, 1974).

(3) Index of Family Relations (IFR). The third dependent variable, level of intrafamilial stress, will be measured using this index, which measures "the degree, severity, or magnitude of a problem that family members have in their relationships with one another...This scale permits the client to characterize the severity of family relationship problems in a global fashion and can be regarded as a measure of intrafamilial stress" (Hudson, 1982, p. 5). Hudson states that the IFR is appropriate for measuring the family environment and for helping clients "deal with problems in relating to the family as a whole" (Hudson, 1982, p. 5).

The level of intrafamilial stress is relevant to the research hypothesis in that a stressful family environment is characteristic of families in which the

adolescent continues to abuse drugs (Frankel, 1985; Friedman, 1985; Kaufman, 1985).

The thirty-question "Feelings Inventory" derived from these three instruments was preceded by twelve "background information" questions. These questions were designed to elicit the following data from each adolescent: (a) age; (b) length of sobriety (abstinence from alcohol and drugs); (c) number of admissions to inpatient adolescent substance-abuse facilities, and approximate dates of admission and discharge; (d) number of different times the adolescent has participated in a family therapy program as part of substance-abuse treatment; (e) the specific type of family therapy with which the adolescent has been involved; (f) how much or little the adolescent feels that family therapy improved his or her relationship with family; (g) how much or little the adolescent feels that family therapy improved his or her feelings about himself or herself; (h) how much or little the adolescent feels that family therapy helped in his or her sobriety; (i) if the adolescent did not receive family therapy does he or she feel that family therapy would have been helpful; (j) how supportive the adolescent feels his or her family is of his or her sobriety; (k) how important the adolescent feels his or her relationship with family is to his or

her sobriety; and (l) whether the adolescent feels his or her substance-abuse was primarily influenced by family pressure or peer pressure.

Administration of the Questionnaire

The complete 42-item instrument was pretested on six adolescents and four young adults. A few reported having problems with the background data items. These problems were solved by a brief explanation being given by the administrator, before the questionnaire was administered. The explanation consisted of describing the purpose of the questionnaire and the type of information which was needed. During the pretest, it became clear that the most accurate information would be gathered if the questionnaire were administered to small groups of adolescents, three to six adolescents at a time.

The questionnaire was administered to the adolescents at the Triangle Club either individually or in small groups. If the adolescents were willing to participate, but unwilling to fill out the questionnaire, the questionnaire was administered orally. This was a slower process, but created good rapport between the administrator and the adolescents. The administrator was readily available to answer

questions while the adolescents were filling out the questionnaires. It was also the administrator's purpose to be sure the adolescents did not talk among themselves, or did not stop before they were finished.

At the residential adolescent facility, the recovery counselors who administered the questionnaires were fully briefed so that they would be able to answer any questions. The counselors administered the questionnaires and remained present while the questionnaires were completed.

Data Analysis

The SPSSX, Statistical Package for Social Sciences, computer system was utilized as the tool for data analysis. The questionnaires generated interval type data. The T test was the technique utilized to analyze the data.

The T test is a statistical technique used to determine the difference between two groups. The purpose of the T test is to determine whether the mean of one group differs significantly from the mean of the other group. The two groups are independent of each other, meaning that subjects are either randomly assigned to each of two groups or random samples are selected from two different populations. The selection

of a member of the first group does not influence the selection of any member of the second group (Bartz, 1988).

In order for the T test to be utilized, the data must be at least interval in nature because the T test calculates means and standard deviations. Scores are measured on random samples from both populations, and the populations from which the samples are drawn must be normally distributed and have approximately the same variability or homogeneity of variance.

The T test is used to test the null hypothesis that the means of two groups are equal to one another. The T test determines whether significant differences exist between two groups on a single dependent variable.

CHAPTER FOUR

PRESENTATION OF RESULTS

The null hypothesis of this study is that there is no difference between adolescents who receive structurally-oriented individual-family therapy as part of substance-abuse treatment and adolescents who do not receive this therapy. No differences exist between the experimental and comparison groups on the variables: (a) self-esteem, (b) depression, and (c) family relations.

Table 1 presents the frequency distribution of adolescents according to age. The findings demonstrated that nearly 50% of the 76 adolescents were in the 16-17 years age group.

Table 1

Frequency Distribution of Adolescents by Age

Variable		Frequency	Percent
AGE			
1.	13-15 years old	21	27.3
2.	16-17 years old	36	46.2
3.	18-19 years old	19	24.4

Table 2 presents the frequency distribution of the adolescents' length of sobriety. Nearly 51% had less than six months of sobriety, while only four percent of the adolescents had more than two years of sobriety.

Table 2

Frequency Distribution of Adolescents' Length of Sobriety

Variable		Frequency	Percent
LENGTH OF SOBRIETY			
1.	less than 6 months	39	50.6
2.	6 months-2 years	34	44.2
3.	more than 2 years	3	3.9

Table 3 presents the frequency distribution of the number of times each adolescent had been admitted to inpatient substance-abuse programs. Nearly 90% of the adolescents had been admitted to inpatient programs one or two times. Few had been admitted more than twice.

Table 3

Frequency Distribution of Number of Times Admitted to Inpatient Substance-Abuse Treatment Programs

Variable	Frequency	Percent
NUMBER OF TIMES ADMITTED TO INPATIENT SUBSTANCE-ABUSE TREATMENT PROGRAMS		
1. 1-2 times	69	89.6
2. 3-5 times	6	7.8
3. 6 or more times	1	1.3

Table 4 presents the frequency distribution of the number of times the adolescents had participated in family therapy as part of inpatient substance-abuse treatment. The majority of the adolescents had participated in family therapy between one and three times.

Table 4

Frequency Distribution of Number of Times Participated in Family Therapy Program as Part of Inpatient Substance-Abuse Treatment

Variable	Frequency	Percent
NUMBER OF TIMES PARTICIPATED IN FAMILY THERAPY PROGRAM AS PART OF INPATIENT SUBSTANCE-ABUSE TREATMENT		
1. none	23	29.9
2. 1-3 times	50	64.9
3. 4 or more times	3	3.9

Table 5 presents a T test analysis of the experimental and comparison groups on the dependent variable of self-esteem. The null hypothesis states that there is no difference in the level of self-esteem between Group (1) and Group (2).

The T test analysis demonstrated differences between the two groups significant beyond the .0001 probability level for all 11 self-esteem variables. The largest T value was indicated for the variable: I feel

that if I could be more like other people I would have it made. This T value was -13.19 with 74 degrees of freedom. The next largest T values (a) -12.83 and (b) -11.13 were indicated respectively for the variables (a) I feel that I bore people, and (b) I am afraid that I will appear foolish to others. 40% of all T values for self-esteem variables were between -9.05 and -9.92. The smallest T value, -7.86, was indicated for the variable: perceived improvement in self-esteem due to family therapy.

Table 5

T Test Analysis of Self-Esteem

Variable	Group	Mean	Std. Dev.	T	Prob.
I feel that if I could be more like other people I would have it made	1	1.5778	0.657	-13.19	.000*
	2	3.6129	0.667		
Perceived improvement in self-esteem due to family therapy	1	2.2444	0.802	-7.86	.000*
	2	4.444	0.527		

* P < .0001, two-tailed

Since the T values for all 11 self-esteem variables were significant at $P < .0001$, the null hypothesis is rejected.

Table 6 presents a T test analysis of the experimental group and the comparison group on the dependent variable of depression. The null hypothesis states that there is no difference in the level of depression between Group (1) and Group (2).

The T test analysis demonstrated differences between Group (1) and Group (2) significant beyond the .0001 probability level. The largest T value was indicated for the variable: I feel that others would be better off without me. This value was -12.92 with 74 degrees of freedom. The next largest T values (a) -11.59, (b) -11.35, and (c) -11.06 were indicated respectively for the variables (a) I get upset easily, (b) I do not sleep well at night, and (c) I feel great in the morning. 50% of all T values for depression variables were between -10.24 and -11.59. The smallest T value, -7.29, was indicated for the variable: I feel blue.

Table 6

T Test Analysis of Depression

Variable	Group	Mean	Std. Dev.	T	Prob.
I feel that others would be better off without me	1	1.556	0.367	-12.92	.000*
	2	2.7742	0.717		
I get upset easily	1	2.1556	0.796	-11.59	.000*
	2	4.2258	0.717		
I do not sleep well at night	1	1.3333	0.522	-11.35	.000*
	2	3.3548	1.018		
I feel great in the morning	1	1.8444	0.737	-11.06	.000*
	2	3.8065	0.792		
I feel blue	1	1.9778	0.783	-7.29	.000*
	2	3.1935	0.601		

* P < .0001, two-tailed

Since the T values for all ten depression variables were significant at P < .001, the null hypothesis is rejected.

Table 7 presents a T test analysis of Group (1) and Group (2) on the dependent variable of family relations. The null hypothesis states that there is no difference in family relations between Group (1) and Group (2).

The T test analysis demonstrates differences between the two groups significant beyond the .0001 probability level for all family relations variables. The largest T value was indicated for the variable: importance of relationship with family to sobriety. This T value was -13.37 with 74 degrees of freedom. The next largest T values (a) -12.47 and (b) -11.42 were indicated for the respective variables (a) supportiveness of family toward sobriety, and (b) I wish I was not part of this family. Approximately 50% of all T values for family relations variables were between -8.46 and -8.97. The smallest T value, -8.46, was indicated for the variable: I get along well with my family.

Table 7

T Test Analysis of Family Relations

Variable	Group	Mean	Std. Dev.	T	Prob.
Importance of relationship with family	1	1.444	0.546	-13.37	.000*
	2	3.6774			
Supportiveness of family towards sobriety	1	1.222	0.420	-12.47	.000*
	2	3.0645	0.854		
I wish I was not part of this family	1	1.0222	0.149	-11.42	.000*
	2	2.6129			
I get along well with my family	1	2.778	0.927	-8.46	.000*
	2	4.3871	0.615		

* P < .0001, two-tailed

Since the T values for all ten family relations variables were significant at P < .0001, the null hypothesis is rejected.

CHAPTER FIVE

SUMMARY AND CONCLUSIONS

The research findings indicate a statistically significant difference between the experimental and the comparison groups on all three dependent variables. The null hypothesis is therefore rejected. Statistical analysis of the data supports the research hypothesis: adolescents who receive structurally-oriented individual-family therapy as part of substance-abuse treatment have (a) higher self-esteem, (b) less depression, and (c) better family relations, than adolescents who do not receive this therapy.

Self-Esteem

The significance of these variables is discussed in the professional literature on adolescent substance-abuse. Stanton (1979) has observed that low self-esteem is common in adolescent substance-abusers, while Bry (1963) has listed low self-esteem as one of the psychosocial characteristics of adolescent substance-abusers. Lettieri (1983) has described adolescent substance-abuse as an attempt by the adolescent to cope with negative feelings and poor self-esteem. The adolescent has certain emotional and psychological

deficits which cause the adolescent to be susceptible to substance-abuse. Woititz (1985) has observed that low self-esteem, accompanied by fear of losing oneself, are characteristic of substance-abusers and their families. Adolescent substance-abusers are insecure and overly dependent on peers' opinions. It is difficult for adolescent substance-abusers to trust others, or to allow others to become emotionally close to them. It is difficult for adolescent substance-abusers to believe that others like them for who they really are. Black (1982) has indicated that adolescent substance-abusers with substance-abusing parents are apt to have particularly low self-esteem. Children of substance-abusing parents are ashamed of their families and of themselves. As adolescents, they often try to leave the family emotionally by abusing substances. Adolescents with substance-abusing parents frequently begin abusing substances because of feelings of isolation and of being different from others. Cermak (1988) has observed that substance-abusers frequently have a sense of low self-esteem, and their sense of self-esteem is based on the reactions of others. Substance-abusers have a poorly-developed sense of identity, and feel that they are innately worthless. Unless the adolescent receives therapy to facilitate the development of a positive

self-image and improved self-esteem, he or she is likely to continue to abuse substances.

Depression

Several theories on substance-abuse have pointed out the significance of depression as a contributing factor to adolescent substance-abuse. Kandel (1974) and Friedman et al. (1980) have observed that the presence of depression in adolescents and their parents is often a predictor of adolescent substance-abuse. Bry (1963) lists depression as a psychosocial characteristic of adolescent substance-abuse. Woititz (1985) has described the prevalence of depression in adolescent substance-abusers and their families. Adolescent substance-abuse is frequently an attempt by the adolescent to relieve feelings of depression through the abuse of alcohol and drugs. Adolescent substance-abusers often feel they cannot allow themselves to express feelings of sadness. Adolescents with substance-abusing parents may abuse substances to cope with fears of loss or abandonment. Cermak (1988) has observed the presence of chronic depression in children of substance-abusing families. These children are at high risk of becoming substance-abusers themselves in adolescence. Adolescent substance-abusers have not

learned how to enjoy themselves without alcohol or drugs, and are not in touch with their emotional needs. Black (1982) has stated that depression, accompanied by low self-esteem, results from the adolescent substance-abuser's feelings of guilt towards his or her family. The feelings of guilt perpetuate the substance-abuse, which in turn perpetuates more guilt, and so on. Unless the adolescent receives therapy, these feelings of guilt and depression will continue. The adolescent will probably continue to abuse substances into adulthood.

Family Relations

The literature has also emphasized the importance of family relations as a factor in adolescent substance-abuse (Kaufman, 1985; Lettieri, 1983; Stanton, 1979). Friedman (1985) and Kandel (1974) have stressed the significance of parental influences as predictors of adolescent substance-abuse. Frankel (1985), Friedman (1985) and Stanton (1979) have described dysfunctional family interaction and communication patterns which perpetuate the cycle of substance-abuse in adolescents. Bry (1963) has listed poor relationship with parents as a psychosocial characteristic of adolescent substance-abusers. Black (1982) has explored the psychodynamics of substance-abusing families. Children of a substance-

abusing parent or parents frequently become acting-out adolescents who abuse alcohol and drugs at an early age. These adolescents frequently develop alcoholism or drug dependence while in their early or mid-teens. Depression, lack of individuation, low self-esteem, anxiety, denial, and physical or sexual abuse are characteristic of substance-abusing families.

Wegscheider (1985), a leading author of co-dependency literature, has explored the destructive rules and roles of substance-abusing families. While not all children of substance-abusers become substance-abusers themselves, a large percentage do. Even if the parents stop abusing substances, the dysfunctional family dynamics are likely to continue unless the co-dependent family system is treated. Adolescents from co-dependent families are likely to abuse substances as a form of acting out, and as a way of coping with their inability to express their feelings, poor self-concept, low self-esteem, and chronic depression. These characteristics are the result of an enmeshed, co-dependent family structure. The adolescent substance-abuser must explore his or her role in the family illness before he or she can successfully recover from substance-abuse. The adolescent returning from substance-abuse treatment to an untreated co-dependent

family system has a poor prognosis for recovery (Bonner et al., 1986).

Cermak (1988) has described the families of adolescent substance-abusers as lacking in both emotional availability of parents and responsible parental controls. Family communication is closed. Roles are non-individualized and rigid. Family members take more responsibility for the feelings and actions of other members than for themselves. This results in a general lack of privacy and disrespect for individual differences among family members. The quality of emotional expression is poor.

Cermak has also observed the predominance of guilt in adolescent substance-abusers. Adolescents frequently abuse alcohol and drugs as a way of dealing with feelings of inadequacy and guilt towards their parents. Unless the family system is treated as a whole, the adolescent's substance-abuse behavior is likely to continue. The adolescent substance-abuser's sense of guilt perpetuates chronic depression and low self-esteem. Unless the adolescent is helped to understand his or her family system, these problems are likely to continue into adulthood, accompanied by continued substance-abuse.

These descriptions of adolescent substance-abusers and their families have indicated that low self-esteem, depression, and poor family relations are significant characteristics of adolescent substance-abusers as a population. As such, these are appropriate variables for predicting the adolescent substance-abuser's likelihood of either relapse or recovery. Therefore, adolescent substance-abusers who receive treatment resulting in higher self-esteem, less depression, and improved family relations, have a better likelihood of recovery than adolescents who do not. On the other hand, adolescent substance-abusers with low self-esteem, a high level of depression, and poor family relations, are a high risk for relapse following discharge from treatment. These statements are supported by the professional literature, as follows: (a) low self-esteem, depression, and poor family relations are characteristic of the adolescent substance-abuse population; (b) adolescent substance-abuse is a cycle, with dysfunctional family dynamics playing a role in the cycle; (c) in order to disrupt the substance-abuse cycle, destructive family dynamics must be restructured into more positive patterns; and (d) recovery from substance-abuse can take place.

Discussion of Dependent Variable Scores

The statistical analysis of findings for this study demonstrates a significant difference between the experimental and comparison groups on all three variables. The presence of a statistically significant difference between the two groups indicates that the independent variable, structurally-oriented individual-family therapy, exercised a significant and measurable impact on the adolescents who received it. Adolescents who were not exposed to the independent variable demonstrated overall lower scores than the experimental group on measurements of all three dependent variables: (a) self-esteem, (b) depression, and (c) family relations.

On the dependent variable of self-esteem, adolescents in the experimental group indicated a greater sense of competence, likableness, attractiveness, individuality, and self-confidence, than the adolescents in the comparison group. The adolescents in the comparison group indicated a greater sense of insecurity, lack of trust, inability to enjoy themselves, fear of appearing foolish, and lack of social skills, than the experimental group. The largest difference in scores between the two groups was

indicated for the feeling of wanting to be less like oneself and more like others.

On the dependent variable of depression, adolescents in the experimental group indicated a sense of motivation, optimism concerning the future, feeling good, and being able to have fun. The adolescents in the comparison group indicated a sense of hopelessness, feeling "blue," getting upset easily, difficulty sleeping, and feeling that others would be better off without them. The largest difference in scores between the two groups was indicated for the feeling of uselessness and being a burden to others.

Of the dependent variable of family relations, adolescents in the experimental group indicated a sense of closeness to family, caring, dependability of family, love, and understanding, more frequently than the adolescents in the comparison group. The adolescents in the comparison group indicated irritability towards family, not getting along with family members, being ashamed of family, and a desire to leave the family, more frequently than adolescents in the experimental group. The largest difference in scores between the two groups was indicated for the feeling of not wanting to belong to one's family.

It can be concluded from a review of the dependent variable scores that the greatest differences between the experimental and control groups lie in the following three areas: (a) feeling content with one's identity versus imitating others, (b) feeling useful versus feeling useless, and (c) feeling close to one's family versus wanting to leave the family. These three areas comprise different aspects of adolescent substance-abuse which have been discussed in the introduction and the review of the literature. The assumption is that adolescents whose functioning improves in these areas will also have an improved prognosis for recovery from substance-abuse. It can be assumed that adolescent substance-abusers whose functioning in these areas either fails to improve or worsens, will have a poorer prognosis for recovery.

The professional literature has indicated that the variables of self-esteem, depression, and family relations comprise a reasonable measurement of the adolescent substance-abuser's basic level of functioning. The research findings for this study thus have indicated that adolescents who have received structurally-oriented individual-family therapy as part of substance-abuse treatment demonstrate a higher level of functioning than adolescents who have not. Since the

literature has suggested that adolescent substance-abusers demonstrate a lower level of intra- and interpersonal functioning than comparable non-abusing adolescents, this outcome is clearly favorable and has implications for social work practice.

Limitations of the Study

Various limitations of the purposive sample were discussed in the methodology chapter of this study. In order to procure a definitively clear outcome on the effect of structurally-oriented family therapy on adolescent substance-abusers, it would have been desirable to study a broader range of subjects for a longer period of time. This study was limited in that it was not possible to pretest the subjects prior to the administration of the independent variable. The study was also limited in that it was not possible to obtain follow-up data on the subjects over a period of several months.

The subjects selected for study were not representative of the adolescent substance-abuse population as a whole, but were representative of the adolescent substance-abuse population of the area from which they were selected. The subjects were disproportionately white and middle-class. It is fair

to estimate that 35% of the subjects came from households in which both parents have college degrees. The subjects in the experimental and comparison groups were not specifically matched in terms of variables such as age, sex, number of times in treatment, or length of abstinence from drugs and alcohol.

It was not possible to factor out certain differences among the subjects, such as age, sex, number of times in treatment, length of substance-abuse or abstinence, and different types of therapy received during childhood and adolescence. The study was also limited in that it was not possible to determine whether the subjects' families had been supportive or non-supportive prior to family therapy.

It was beyond the scope of this study to determine a direct association between the independent variable and an improved prognosis for recovery from adolescent substance-abuse. Measurement of the length of the adolescents' sobrietyperiod, and the quality of this sobriety period, subsequent to family therapy, could not be accomplished. Consequently it could not be determined that structurally-oriented individual-family therapy has a direct positive effect on adolescents' recovery from substance-abuse.

Suggested Research Directions

Several directions for future research are suggested by the limitations of this study. It would be desirable to study a large, randomly selected, representative sample of adolescent substance-abusers. Pre-testing the subjects prior to administration of the independent variable would provide a more accurate picture of the effects of the intervention. It would be highly desirable to pre-test the subjects, administer the independent variable, then post-test the adolescents at intervals over a period of several months or years. This procedure would yield definitive outcome data on the long-term effects of family therapy on recovery from adolescent substance-abuse.

The literature has pointed out that most studies of adolescent substance-abusers are lacking in follow-up data. Adolescents are a difficult population to follow over an extended period of time. Maturation differences must be taken into account, and the issue of parental consent also makes adolescents a more problematic population for study than a comparable group of adults. However, extended-time studies with definitive results are needed in the adolescent substance-abuse field in

order to determine which interventions are most effective with this population.

A study should be conducted with minority adolescent substance-abusers, since cultural issues must be considered when treating this population. A separate study is suggested for female adolescents, since the problem of substance-abuse may be regarded differently from a female perspective. Substance-abuse treatment for girls may require a different orientation than that for boys. Racial, cultural, and gender issues should be emphasized in studies of adolescents, because adolescents in particular, in the midst of a transitional society, are in a state of intense personal transition.

Any future studies of adolescent substance-abusers should exercise the humanistic value system, regarding the adolescent as a human being with the desire to reach his or her full potential.

CHAPTER SIX

IMPLICATIONS FOR SOCIAL WORK PRACTICE

The problem of adolescent substance-abuse is a pressing contemporary social issue affecting families across a broad range of cultural and socioeconomic backgrounds. The rising rate of substance-abuse among adolescents has been accompanied by increasing public awareness of the problem, and by an insufficiency of funds to correct the problem.

As public-service announcements on adolescent substance-abuse appear with ever-increasing frequency on radio and television, drug-abusers and dealers in most communities state that the cost of an ounce of cocaine is now approximately half of what it was eight or ten years ago. The affordability and availability of cocaine and crack to adolescents has resulted in a wave of increased substance-abuse among both urban and rural adolescents. The increase in adolescent substance-abuse has out-distanced the availability of federal, state and local programs to deal with this problem. Private substance-abuse treatment is available in most communities for adolescents whose parents have the medical insurance or financial resources to pay for treatment. However, adolescents without insurance or resources are dependent upon government-subsidized

treatment programs. It seems unlikely that government-sponsored programs will be able to expand and multiply rapidly enough to handle the high rate of adolescent substance-abuse which will probably continue to rise for the next few years. The tendency of adolescent substance-abusers to relapse also adds to the difficulty of treatment. With a rising rate of adolescent substance-abuse and an inadequacy of adolescent treatment programs, it is essential to determine which types of interventions are effective with this population and to put these interventions into practice.

Determining the effectiveness of any intervention is a necessary aspect of accountability in social work practice. The limited amount of funds available for financing substance-abuse treatment programs makes accountability a necessity. By demonstrating the effectiveness of structurally-oriented individual-family therapy with adolescent substance-abusers, the researcher makes it possible for demonstrators and clinicians to justify including this intervention in adolescent substance-abuse treatment programs.

The urgency of proving effective methods of treatment for adolescent substance-abuse cannot be overemphasized. The literature has indicated that adolescents who abuse substances are handicapped in

their ability to master developmental skills and life tasks. Consequently, these adolescents are unlikely to mature into well-adjusted, high-functioning adults. A large percentage of adolescent substance-abusers continue to abuse alcohol and drugs into adulthood. As adults, they must not only be treated for substance-abuse, but helped to overcome the psychological and social deficits resulting from a developmentally impoverished adolescence.

Prevention is a critical aspect of social work practice. A knowledge of the family's role in the development of adolescent substance-abuse can be utilized by social workers to help prevent the problem from occurring. Structural family therapy with families of acting-out children and adolescents may lessen or stop the acting-out behavior before it reaches the substance-abuse stage.

The professional literature has suggested that family therapy should be included as part of adolescent substance-abuse treatment. This study has suggested that the structurally-oriented individual-family model is the appropriate method of family therapy for adolescent substance-abuse treatment.

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APPENDICES

APPENDIX A: DETAILED STATISTICAL TABLES

APPENDIX B: T TEST ANALYSIS OF HELPFULNESS OF FAMILY THERAPY TO SOBRIETY

APPENDIX C: T TEST ANALYSIS OF FAMILY PRESSURE VERSUS PEER PRESSURE

APPENDIX A: DETAILED STATISTICAL TABLES

Table 8

T Test Analysis of Self-Esteem

Variable	Group	Mean	Std. Dev.	T	Prob.
Perceived improvement in self esteem due to family therapy	1	2.2444	0.802	-7.86	.000*
	2	4.4444	0.527		
I feel that people would not like me if they really knew me well	1	1.5778	0.690	-10.35	.000*
	2	3.3548	0.798		
I feel that I am a very competent person	1	2.6222	0.806	-9.59	.000*
	2	4.2258	0.560		
I think I make a good impression on others	1	2.4667	0.751	-11.02	.000*
	2	4.2258	0.560		
I feel that I need more self-confidence	1	2.5778	1.011	-9.33	.000*
	2	4.4839	0.626		

Table 8

T Test Analysis of Self-Esteem

Variable	Group	Mean	Std. Dev.	T	Prob.
I feel ugly	1	1.8000	0.661	-9.92	.000*
	2	3.3226	0.653		
I feel that others have more fun than I do	1	1.9118	0.733	-9.05	.000*
	2	3.4516	0.723		
I feel that I bore people	1	1.3556	0.484	-12.83	.000*
	2	3.0968	0.700		
I feel that if I could be more like other people I would have it made	1	1.5778	0.657	-13.19	.000*
	2	3.6129	0.667		
I feel that I am a likeable person	1	3.2889	0.661	-8.95	.000*
	2	4.5484	0.506		
I am afraid that will appear foolish to others	1	1.8222	0.777	-11.13	.000*
	2	3.8710	0.806		

Table 9

T Test Analysis of Depression

Variable	Group	Mean	Std. Dev.	T	Prob.
I feel blue	1	1.9778	0.783	-7.29	.000*
	2	3.1935	0.601		
I have a hard time getting started on things I need to do	1	2.5333	0.919	-9.39	.000*
	2	4.2903	0.588		
I do not sleep well at night	1	1.3333	0.522	-11.35	.000*
	2	3.3548	1.018		
I feel that the future looks	1	3.1556	0.976	-8.24	.000*
	2	4.7097	0.461		
I feel downhearted	1	1.6000	0.495	-10.24	.000*
	2	3.1290	0.806		

Table 9

T Test Analysis of Depression

Variable	Group	Mean	Std. Dev.	T	Prob.
I feel that others would be better off without me	1	1.1556	0.367	-12.92	.000*
	2	2.7742	0.717		
I get upset easily	1	2.1556	0.796	-11.59	.000*
	2	4.2258	0.717		
It is hard for me to have a good time	1	1.2222	0.420	-10.28	.000*
	2	2.7419	0.855		
I feel great in the morning	1	1.8444	0.737	-11.06	.000*
	2	3.8065	0.792		
I feel that my situation is hopeless	1	1.2000	0.405	-9.60	.000*
	2	2.7097	0.938		

Table 10

T Test Analysis of Relationship with Family

Variable	Group	Mean	Std. Dev.	T	Prob.
Perceived improvement in family relations due to family therapy	1	2.0222	0.866	-8.83	.000*
	2	4.6667	0.500		
Supportiveness of family towards sobriety	1	1.2222	0.420	-12.47	.000*
	2	3.0645	0.854		
Importance of relationship with family	1	1.4444	0.546	-13.37	.000*
	2	3.6774	0.909		
The members of my family really care about each other	1	2.8889	1.153	-8.75	.000*
	2	4.8065	0.477		
My family gets on my nerves	1	2.2000	0.726	-8.84	.000*
	2	3.7097	0.739		
I can really depend on my	1	2.9111	1.041	-8.48	.000*
	2	4.6452	0.551		

Table 10

T Test Analysis of Relationship with Family

Variable	Group	Mean	Std. Dev.	T	Prob.
I get along well with my family	1	2.7718	0.8927	-8.46	.000*
	2	4.3871	0.615		
I wish I was not part of this family	1	1.0222	0.149	-11.42	.000*
	2	2.6129	0.919		
There is no sense of closeness in my family	1	1.2222	0.420	-9.16	.000*
	2	2.8065	1.046		
My family does not understand me	1	1.7778	0.735	-10.07	.000*
	2	3.6129	0.844		
There is a lot of love in my family	1	3.1333	0.991	-8.72	.000*
	2	4.8065	0.477		
I feel proud of my family	1	2.7333	1.031	-9.08	.000*
	2	4.6129	0.615		
Other families seem to get along better than ours	1	2.0889	0.848	-8.97	.000*
	2	4.0000	1.000		

APPENDIX B: T TEST ANALYSIS OF HELPFULNESS OF FAMILY THERAPY TO SOBRIETY

Table 11

T Test Analysis of Helpfulness of Family Therapy to Sobriety

Variable	Group	Mean	Std. Dev.	T	Prob.
Perceived helpfulness of family therapy to sobriety	1	2.2444	0.957	-8.14	.000*
	2	4.8889	0.333		
Perceived helpfulness of family therapy to adolescents who did not receive it	1	1.9000	0.968	-0.75	.464
	2	2.3333	0.577		

APPENDIX C: T TEST ANALYSIS OF FAMILY PRESSURE VERSUS PEER PRESSURE

Table 12

T Test Analysis of Family Pressure versus Peer Pressure

Variable	Group	Mean	Std. Dev.	T	Prob.
Family pressure versus peer pressure as primary motivator towards substance-abuse	1	1.7778	0.636	-9.91	.000*
	2	3.1290	0.499		

ABSTRACT

SOCIAL WORK

WYLLY, BARBARA B.A. UNIVERSITY OF NORTH CAROLINA, 1978

SIGNIFICANCE OF FAMILY THERAPY IN TREATMENT OF ADOLESCENT SUBSTANCE-ABUSERS

Advisor: Dr. Amos Ajo

Thesis dated: April 10, 1989

The overall objective of this study is to investigate family factors in adolescent substance-abuse and the significance of family therapy as part of adolescent substance-abuse treatment. The proposal underlying the study was that adolescents who received structurally-oriented individual-family therapy during inpatient substance-abuse treatment would demonstrate a higher level of functioning on several variables than adolescents who did not receive this type of therapy.

A static group comparison design was used in the study. The adolescents' level of functioning was defined in terms of the following variables: (a) self-esteem, (b) depression and (c) attitudes towards family. A questionnaire was administered to adolescents in clinical and community settings. The results of the study indicated a direct and positive association between structurally-oriented individual-family therapy and a higher level of functioning.